P_X

PRESCRIPTION & LETTER OF MEDICAL NECESSITY

PATIENT NAME*			DOB*	DATE OF INJURY	DATE OF SURGERY	
PRIMARY PHONE*			SECONDARY PHONE/ EMAIL			
<u>_</u>	E-STI	м ———				
		Zynex NexWave + Monthly Supplies and a Conductive Garment when applicable	DX Code(s)	·		
		Zynex E-Wave (NMES Only) + Monthly Supplies	Length of Need: ☐ Life-time ☐ 3-18 Months (if unchecked = Life-time)			
Substitution for this device is NOT ALLOWED without my written approval					!	
_	SPINAL ORTHOSIS (FILL OUT PATIENT EQUIPMENT PROTOCOL ON BACK OF PATIENT HANDOUT)					
	Horizon Lumbosacral Orthosis (Prefabricated) (Purchase Only) DX Code(s)					
	The Horizon Lumbosacral Orthosis is medically necessary and prescribed to: □ reduce pain by restricting mobility of the trunk; or □ facilitate healing following an injury to the spine or related soft tissue: or □ facilitate healing following a surgical procedure on the spine or related soft tissue; or □ otherwise support weak spinal muscles and/or deformed spine. Quantity to be Dispensed: Frequency of Use:					
	<u>P</u>	lease document in patient's chart, the above	checked reason(s	s) for prescribing and f	ax with Rx	
CERVICAL TRACTION (FILL OUT PATIENT EQUIPMENT PROTOCOL ON BACK OF PATIENT HANDOUT) Home Cervical Traction (Purchase Only) (Saunders or ComforTrac) DX Code(s) Our Home Cervical Traction Devices are medically necessary because the patient requires greater than 20 pounds of force.						
HOT/COLD THERAPY (FILL OUT PATIENT EQUIPMENT PROTOCOL ON BACK OF PATIENT HANDOUT) JetStream® Hot/Cold circulating pump & therapy blanket DX Code(s)						
CLINI	c Add	RESS	Сіту		ST. ZIP	
PHONE		FAX				
PRESCRIBER'S SIGNATURE*		DATE*				
PRINTED NAME*		NPI*				

IF THIS DEVICE WAS REQUESTED BY ANOTHER MEDICAL PROVIDER, PLEASE INCLUDE THEIR NAME/ADDRESS/ZIP HERE

I CERTIFY THAT THE EQUIPMENT AND SUPPLIES I PRESCRIBED ARE MEDICALLY NECESSARY FOR THIS PATIENT'S WELL-BEING; THIS IS NOT PRESCRIBED AS CONVENIENCE EQUIPMENT. IN MY PROFESSIONAL OPINION, THE EQUIPMENT IS BOTH REASONABLE AND NECESSARY IN REFERENCE TO THE ACCEPTED STANDARDS OF MEDICAL PRACTICE AND TREATMENT FOR THIS PATIENT'S CONDITION. SUBSTITUTION FOR THIS DEVICE IS NOT ALLOWED WITHOUT MY WRITTEN APPROVAL.

FAX RX To: +1 (800) 495-6695 Email Rx To: orders@zynex.com

Please Review Hot/Cold therapy contraindications prior to prescribing for patient

CONTRAINDICATION - WHEN NOT TO USE HOT THERAPY

DO NOT use hot therapy on patients with any of the following contraindications:

- History of heat injury or adverse reactions to hot therapy
- Incoherence due to sedation, anesthesia, coma or sleep
- Decreased skin sensitivity or localized circulation or wound healing problems
- Arteriosclerosis or atherosclerosis
- Localized malignancy in treatment area
- Hypersensitivity to heat
- Local tissue infection, swelling or inflammation

DO NOT APPLY ABDOMINALLY IF PREGNANT

CONTRAINDICATION - WHEN NOT TO USE COLD THERAPY

DO NOT use cold therapy on patients with any of the following contraindications:

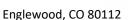
- History of cold injury, frostbite or adverse reactions to cold therapy
- Incoherence due to sedation, anesthesia, coma or sleep
- Decreased skin sensitivity or localized circulation or wound healing problems, including those caused by multiple surgical procedures
- Circulatory syndromes due to Raynaud's disease, Buerger's disease, peripheral vascular disease, vasospastic disorders, or hypercoagulable clotting disorders
- Hand/wrist or foot/ankle surgery exhibiting polyneuropathy
- Hypersensitivity to cold
- Local tissue infection
- Diabetes

DO NOT USE ON CHILDREN UNDER 12 YEARS OF AGE

Please Fax To: +1 (800) 495-6695

Include Patient Demographics

For LSO orders include patient chart notes supporting Rx





Patient Support: (800) 495-6670



HERE'S HOW TO OBTAIN YOUR PRESCRIBED MEDICAL DEVICE



• Zynex will text and call you (usually the same day we receive your Rx!)



Step 2

Have your medical insurance information ready



Step 3

 Zynex will ship your device directly to your home



You can learn how to use the NexWave by watching the instructional video at http://www.zynex.com/nw

If you have not heard from us within 24 hours, please call Patient Support at (800) 495-6670

(SEE BACK FOR: EQUIPMENT USE)

Equipment Use Protocol

Patient Name _____

Spinal Bracing Equipment Use Protocol ———— **Pain Management Use** ☐ Wear min./day and increase wear time by min. every day(s) ☐ Wear spinal brace while performing the following: ☐ Sitting ☐ Standing ☐ Walking ☐ Exercising ☐ Other Instructions: **Post Operative Use** ☐ Day ____ through Day ____ Wear continuously with a break of ____min. every ____hour(s) ☐ Day through Day Wear continuously with a break of min. every hour(s) ☐ Wear spinal brace while performing the following: ☐ Sitting ☐ Standing ☐ Walking ☐ Exercising ☐ Other______ Instructions: Cervical Traction Equipment Protocol (Tx = Treatment) ——— Choose Degree of Flexion: ☐ 10° ☐ 15° ☐ 20° ☐ **Tension Type:** Sustained lbs. of Force min./Tx Tx/Day ☐ **Tension Type:** Intermittent ____ lbs. of Force ____ min. of ON Time ____ min. of OFF Time ____ Tx/day Hot/Cold Therapy Equipment Use Protocol (Tx = Treatment) — Cold Therapy (40° - 50°): ☐ Day ____ through Day ____ Use continuously with a break of ____min. every ____hour(s) ☐ Day ____ through Day ____ Use: ___min./Tx every ____hour(s) ☐ Use after exercise for ____min./Tx Hot Therapy: (80° - 120°) ☐ Use after day number ☐ Before exercise: min./Tx ☐ Loosen stiff muscles/Joint: min./Tx